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(*Zentralb. f. Gynaek.*, 1913, vol. xxxxii, p. 529) has collected eleven cases. There seemed to be no great difficulty with the birth of the child, Neugebauer's own case having a spontaneous delivery, but the delivery of the placenta gave difficulty, manual extraction being necessary in a few. Each of these cases had been operated upon by some method. In each the uterine wall had been rather extensively incised and sutured. In the presence of this scar each case was delivered without accident by vagina. This is interesting. It would seem to me that the best present-day obstetricians would prefer an abdominal Caesarean section before the advent of labor.

PREGNANCY AND LABOR FOLLOWING RESECTION OF OVARY.

BY FREDERICK W. JOHNSON, M.D., F.A.C.S., BOSTON.

I REPORT this case to encourage those who do resections, where there is a chance of saving even a little healthy ovarian tissue.

The patient entered the Carney Hospital Dec. 11, 1913 (Case No. 1897) for the relief of backache and pain in both ovarian regions.

She was 24 years of age, married five years, and had had two children, the last one having been born two years previous to entering. The following symptoms date from the last confinement (2 years' duration): Irregular menstruation (once during this period went four months without menstruating), diminution in amount of flow and number of days, dysmenorrhea, profuse leucorrhea, burning and scalding during micturition. Gonococci not found. Last unwell, Nov. 23, 1913. Appendix removed five years before.

Diagnosis. Cystic left ovary. Ovarian cyst (right). December 13, 1913, the uterus was curetted. On opening the abdomen there were found chronic salpingitis of the distal half of each tube, an ovarian cyst of the right ovary the size of a hen's egg, a cystic left ovary, and the cecum adherent to the scar of the previous appendix operation. The ovarian cyst and eight-tenths of the left ovary were removed and the uterus suspended.

Pathologist's Report. Cystic ovary, dermoid cyst of ovary, and moderate hyperplasia of uterine mucosa.

Menstruation did not occur for three months after the operation. Was irregular (going over) until February 18, 1915 (2 years and 2 months). Flowed one day in March and April, 1915.

April 22, 1915, I found the uterus enlarged, both breasts enlarged and containing fluid and areolae darkened.

There were increased frequency of micturition, morning sickness, increased vaginal discharge and violet coloration of the introitus vaginae. She was "quite sick with fainting spells the first three months, but from then on was quite well."

November 26, 1915, she delivered herself of a nine-pound girl. Dr. J. S. H. Leard, who attended her, reported to me that the labor and convalescence were normal.

New Instrument.

A TABLE FOR THE REDUCTION OF DISLOCATIONS OF THE HIP AND OPERATIVE TREATMENT OF THE FEMUR AND HIP JOINT.*

BY HENRY J. FITZSIMMONS, M.D., BOSTON.

THE following illustrations and specifications are intended to place before the orthopedic surgeon a mechanical aid to more efficient work. In a previous paper the writer described a table designed to be used in the reduction of difficult congenitally dislocated hips. The table, after a year's use, showed that the principles upon which it was built were sound; but that certain of the mechanical details were faulty. The present table has been designed after study of the failures and difficulty of the past, and now has been used sufficiently to justify this report.

Motion and the proper amount of force, directed as desired and when desired, are absolutely essential to the permanent success of any form of mechanical help in the reduction of congenitally dislocated hips. The pelvis must be held absolutely, and the mechanics for doing so must be so arranged as not to injure the skin or soft parts. It is the author's belief that this has been accomplished, therefore the following description is respectfully submitted.

The table is made of standard gauge iron pipe, and is 24 in. wide, 32 in. high, and 48 in. long. The shoulder and head-rest 1 (Fig. I) is made of sheet steel and is adjustable upon the top bars of the table Tr. It is shaped to fit the tapering of the lower thorax and to prevent incorporation in the upper portion of the plaster spica, which is placed to maintain the reduced hips after reduction. 3, The metal plates, which were modeled to fit accurately over the anterior superior spines and the iliac crests, are adjustable in all directions by means of the universal joint C, and the swing connection at D. The uprights E and E′ are carried upon the firm T, which is adjustable through its sliding possibilities upon the lower rail, Lr., thus accommodating to any length of body and permitting a more definite downward or sideways hold on the iliac bones. The sacral rest G is a plate upon which rests an individually fitted plate, modeled for each case, and which should include the posterior iliac spines. This is fitted loosely to and upon the firm T′, which is made of tubing, carrying a worm, which gives adjustability in the perpendicular plane. This T′ is adjustable on the long diameter by its sliding possibility upon the lower bars of the table. This bar T′ also carries the trochanteric push H, which is adjustable through the sliding joint J and the ball and socket joint K. This adaptability permits the cap L to be placed beneath the trochanter and firm constant pressure exerted by means of the screw and worm at M, in any direction. The perineal posts N of two bars, fitted

* Demonstrated upon two cases before the Clinical Congress of Surgeons of North America, October 28, 1915, Children's Hospital, Boston, Mass.
Demonstrated before the Interurban Orthopedic Club, December 31, 1915, Children's Hospital, Boston, Mass.

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